20.a. Pregnancy-Related and Post Partum Services for 60 Days After the Pregnancy Ends:

- The following are extended services for pregnant women which vary in amount, duration, and scope from other services under this State Plan.

- For the purposes of item 20.a., "physician" includes a doctor of osteopathy pursuant to 42 CFR §440.50(a).

PRENATAL RISK ASSESSMENT: All pregnant women receiving prenatal care services funded by the State of Minnesota will be screened for risk of a poor birth outcome. Factors in the assessment will include:

(1) lifestyle risk, including use of alcohol and illicit or non-prescription drugs, smoking, diet, and activity;
(2) medical risk;
(3) genetic risk;
(4) pre-term birth risk;
(5) psycho-social risk, including lack of emotional supports, stress, and lack of parenting skills.

Risk assessment activities include:

(1) To be eligible for MA reimbursement for the delivery of the enhanced perinatal services, a physician, ~~or~~ certified nurse midwife, or nurse practitioner shall complete a risk assessment at the recipient's first prenatal visit (and, optionally, again at approximately 24-28 weeks gestation) on the form supplied by the Department of Human Services.

(2) Physicians, ~~and~~ certified nurse midwives, and nurse practitioners must submit the completed risk assessment form to the Department of Human Services.

(3) The primary provider (physician, ~~or~~ certified nurse midwife, or nurse practitioner) will receive a payment for each risk assessment form submitted to the Department (2 payments per pregnancy; limited to 4 payments per year; i.e. more than one pregnancy in a year).

23.a. Pregnancy-Related and Post Partum Services for 60 Days After the Pregnancy Ends. (continued)

Eligible Providers: Completion of the risk assessment and submission to Department must be performed by the enrolled primary physician, ~~or~~ certified nurse midwife, or nurse practitioner.

AT RISK ANTEPARTUM MANAGEMENT: If a woman is found to be at risk of a poor birth outcome based on the prenatal risk assessment, the primary physician or certified nurse midwife is eligible for MA reimbursement for additional time management based on the woman's risk status.

CARE COORDINATION: The care coordinator for the at risk pregnant recipient must remain consistent and the relationship between the care coordinator and the recipient must be ongoing, with regular interaction, and based on trust if the process is to be effective. Care coordination services are based upon an individualized plan of care for each at risk pregnant woman after assessing the recipient's needs and risks. The care coordinator must make appropriate referrals to resources that will support a healthy pregnancy and improve birth outcomes, monitor recipient progress, synchronize services, advocate for the recipient to assure access to necessary services and maximize use of the most cost effective and appropriate services.

Care coordination services include:

(1) Definition of a pregnant recipient as "at risk" and requiring special needs based on the initial assessment by the primary physician, ~~or~~ nurse midwife, or nurse practitioner utilizing the Department's risk assessment form.

(2) Development of an individual plan of care that addresses the recipient's specific needs and risks related to the pregnancy.

(3) Involvement of the recipient, family, and recipient support network in the assessment and plan of care.

20.a. Pregnancy-Related and Post Partum Services for 60 Days After the Pregnancy Ends. (continued)

(4) Provision of enhanced perinatal services by the primary provider him/herself or coordination of referrals to appropriate community resources and health care providers eligible for addressing and meeting the recipient's needs related to the pregnancy.

(5) Advocacy for the recipient in working with the various health care providers.

(6) Directly monitoring on an ongoing basis, or ensuring that monitoring is done to determine whether the recipient is, in fact, receiving enhanced perinatal services in a timely and economical manner and that the service is of expected and adequate quality.

Eligible Providers: Care coordination services must be performed by the primary physician, physician assistant, certified nurse-midwife, licensed registered nurse, or nurse practitioner. If performed by a registered nurse, the care plan and critical educational needs identified in the plan must be reviewed and approved by the recipient's primary provider ~~(physician or nurse midwife)~~ and a copy included in the recipient's medical record.

PRENATAL HEALTH EDUCATION I: Health education for the at risk pregnant woman is a core intervention that is preventive, non-invasive and resource-efficient, and enhances compliance with the recipient's individualized plan of care. Educational services will be based upon the client's identified risks/needs as determined by the Department of Human Services's risk assessment form, as well as consultation and agreement between the care coordinator and recipient. Designated "at risk" clients require innovative and individualized approaches to prenatal care to effectively meet their educational needs. The Department's educational interventions will target risk factors, medical conditions and health behaviors that can be alleviated or improved through education. Educational services will begin with the initial assessment visit and continue throughout the perinatal period. Services can be provided on a one-to-one basis, in small-group settings, or in classes

20.a. Pregnancy-Related and Post Partum Services for 60 Days After the Pregnancy Ends. (continued)

individualized to the client's own needs and interests. The prenatal health education sessions promote behavior changes in the recipient's daily life that will support a healthy pregnancy and result in an improved perinatal outcome.

Prenatal health education will provide information on:

(1) Description and importance of continued prenatal care
(2) Normal changes due to pregnancy (specific to trimester):
    (a) Maternal anatomy and physiology
    (b) Fetal development
    (c) Emotional/psychosexual issues
(3) Comfort measures
(4) Self-care during pregnancy
(5) Pregnancy danger/warning signs
(6) Specific medical conditions
    (a) Diagnosis and significance during pregnancy
    (b) Treatment: medications, activity level, options, and rationale
    (c) Appropriate referrals

Prenatal Health Education I must include information to prepare the client for the birth process when the recipient is near the end of the second trimester or early third trimester.

(1) Anatomy and physiology of labor and delivery
(2) Coping skills
(3) Medical management
(4) Hospital procedures
(5) Danger signs
(6) Communication with health providers

A pregnant woman may contribute toward preventing preterm labor and delivery. An at risk woman must be instructed in order to provide optimal preventive care:

(1) Symptoms of preterm labor
(2) Self-detection of preterm labor
(3) Treatment
(4) Preventive measures

20.a. Pregnancy-Related and Post Partum Services for 60 Days After the Pregnancy Ends. (continued)

Eligible Providers: Prenatal Health Education I services must be performed by a physician, physician assistant, certified nurse-midwife, licensed registered nurse, nurse practitioner, or a health educator with either a baccalaureate level degree in health education or higher and/or SOPHE (Society for Public Health Education) certification.

PRENATAL HEALTH EDUCATION II: LIFESTYLE AND PARENTING SUPPORT

Description: Lifestyle and parenting support educational services supplement the Prenatal Health Education I services, and are necessary for recipients who require more time and specialized education to evoke change in risk behaviors and lifestyles as determined by the Department of Human Services's risk assessment tool. Behavior and lifestyle changes resulting from this early and consistent education may also have long term impacts on improving the health of the mother, baby, and subsequent pregnancies.

Providers will address the individual needs of the at risk pregnant woman which may include:

(1) Education/assistance to stop smoking
  (a) Decrease smoking alternative
  (b) Effects of smoking on mother and fetal development
  (c) Referral to support program to quit

(2) Education/assistance to stop alcohol consumption
  (a) Emphasize importance of no alcohol during pregnancy
  (b) Effect of alcohol on fetal development
  (c) Referral to support program if needed

(3) Education/assistance to stop use of street drugs
  (a) Emphasize no safe limit
  (b) Effects of drugs on fetal development
  (c) Referral to support program if needed

(4) Education on safe use of OTC/prescription drugs
  (a) Consult with primary provider

20.a. Pregnancy-Related and Post Partum Services for 60 Days After the Pregnancy Ends. (continued)

(5) Environmental/occupational hazards
- (a) Identify potential exposure to hazard in client's own environment
- (b) Effects on fetal growth and development
- (c) Efforts to minimize exposure
- (d) Referrals for follow-up if needed

(6) Stress management
- (a) Relaxation techniques
- (b) Job/unemployment/school problems
- (c) Support services
- (d) Communication with health care providers
- (e) Coping skills

(7) Communication skills and resources
- (a) Family support systems
- (b) Health care providers

(8) Building of self-esteem

(9) Prenatal parenting; bonding
- (a) Identify and affirm prenatal parenting behaviors

(10) Parenting skills to meet the physical, emotional, and intellectual needs of the infant
- (a) Infant needs/cares
- (b) Nurturing
- (c) Infant feeding preparation
- (d) Referral to community resources, if needed

(11) Planning for continuous, comprehensive pediatric care following delivery.

Eligible Providers: Prenatal Health Education II services must be performed by a physician, physician assistant, certified nurse-midwife, licensed registered nurse, nurse practitioner, health educator with either a baccalaureate level degree in education or higher and/or SOPHE (Society for Public Health Education) certification, or a baccalaureate or master's prepared social worker.

20.a. Pregnancy-Related and Post Partum Services for 60 Days After the Pregnancy Ends. (continued)

PRENATAL NUTRITION EDUCATION:

Description: A nutritional assessment with follow-up reassessment and education for the at risk pregnancy must identify nutritional risks and problems the pregnant woman may already have or be in danger of developing as determined by the risk assessment form. An individualized nutrition care plan will be developed for each pregnant woman based on the assessment of her nutritional status with necessary referrals to food assistance programs as appropriate. The nutrition care plan will be incorporated into the overall individualized plan of care for each woman, and will address the prevention/resolution of identified risks and problems. Nutrition interventions will include individual as well as group nutrition education and follow-up, and will provide information that will assist the pregnant woman in making informed nutritional choices and accepting responsibility to change nutritional behaviors to support a healthy pregnancy and result in an improved perinatal outcome.

The nutritional assessment and education component will include:

(1) An initial assessment of "nutritional risk" based upon height, current and pre-pregnancy weight status, laboratory data, clinical data, and self-reported dietary information utilizing the Department's risk assessment tool.

(2) Ongoing assessment of the pregnant woman's nutritional status (at least once every trimester) as evidenced by dietary information, adequacy of weight gain in pregnancy, other measures to assess uterine/fetal growth, laboratory data, and clinical data.

(3) Development of an individualized nutrition care plan (to be included in recipient's medical record) which addresses the recipient's own nutritional deficits, prioritization of nutritional needs, proposed interventions and time frame with expected outcomes.

20.a. Pregnancy-Related and Post Partum Services for 60 Days After the Pregnancy Ends. (continued)

(4) Referral to food assistance programs, if indicated (WIC, food stamps, Mothers and Children Program)

(5) Nutritional interventions; either individual or group education:
- (a) Nutritional requirements of pregnancy are linked to fetal growth and development
- (b) Recommended Dietary Allowance for normal pregnancy
- (c) Appropriate weight gain
- (d) Importance of vitamin/iron supplements and recommendations for taking them
- (e) Infant nutritional needs and feeding practices, including breast-feeding

(6) Incorporation of pre/postnatal exercise/physical activity program

Eligible Providers: A nutritional assessment and nutrition education must be performed by the primary care physician, physician assistant, certified nurse-midwife, registered nurse with specialized training, nurse practitioner, or a qualified dietitian or nutritionist.

POST PARTUM FOLLOW-UP HOME VISIT:

Description: There are many possible sources of stress when the mother takes the new baby home, including: feelings of inadequacy in caring for the child; changes in interpersonal relationships; and new burdens of parental responsibility. This visit gives special emphasis for at risk mothers and infants by following up on pre-identified "risk" behaviors and/or medical conditions. Reinforcement and support must be provided when positive behavior changes related to the pregnancy have been required and incorporated into the recipient's lifestyle. Anticipatory guidance about infant care and development will encourage and promote healthier parenting. It is also imperative for the parent(s) to be able to detect signs and symptoms of distress to the infant that require prompt or emergency treatment. The home visit is necessary to anticipate further needs of the mother or infant that may require additional home-visits or referral to appropriate health

20.a. Pregnancy-Related and Post Partum Services for 60 Days After the Pregnancy Ends. (continued)

and social service providers. The post partum follow-up home visit will be in addition to and separate from the six week post partum visit with the recipient's primary provider and will be made within the first two weeks after the mother's discharge from the hospital. Individualized information and consistent reinforcement of previously provided services (based on the care plan) will be offered to the recipient at this time.

The provider will address the following:

(1) Assessment of mother's health
  (a) Follow-up "risk" behaviors, and medical conditions
  (b) Support of positive changes made to date

(2) Physical/emotional changes postpartum
  (a) Anticipatory guidance regarding relationship with partner
  (b) Sexual responses
  (c) Potential stress with family
  (d) Nutritional needs
  (e) Physical activity/exercise

(3) Contraception

(4) Parenting skills/support
  (a) Adapting to parenthood
  (b) Parent/child relationship
  (c) Child care arrangements and support

(5) Grief support if unexpected outcome

(6) Parenting sick/preterm infant, if indicated
  (a) Follow-up on "risk" factors and conditions

(7) Assessment of infant's health
  (a) Infant weight/growth
  (b) Infant development and abilities

20.a. Pregnancy-Related and Post Partum Services for 60 Days After the Pregnancy Ends. (continued)

(8) Infant care
- (a) Feeding and infant nutritional needs
- (b) Recognition of illness in the newborn
- (c) Accident prevention
- (d) Immunizations and pediatric care

(9) Identification of community health resources
- (a) Mother
- (b) Infant

(10) Referral to appropriate community health resources
- (a) Mother
- (b) Infant

Eligible Providers: This visit must be performed by the client's primary care physician, physician assistant, certified nurse-midwife, licensed registered nurse, or nurse practitioner who is able to provide and anticipate needs for guidance. The provider must be able to provide the necessary follow-up and referrals to appropriate medical assistance eligible providers and social service agencies.